COMPLETE AND SEND THIS FORM TO:

New Jersey State Referee Committee
109 White Oak Ln, Suite 72H
Old Bridge, NJ 08857

ACCIDENT PROOF OF LOSS/CLAIM FORM

$100.00 Deductible

52 week eligibility period

Please read instructions on Page 3 before completing this form

SECTION I - TO BE COMPLETED BY CLAIMANT

1. **NAME:** (first) _____ (last)_____
2. **ADDRESS**: _____ (city) _____ (state) _____ (zip code)_____
3. **TELEPHONE:** _____ **BIRTHDATE:** ___/___/___ **GENDER:** ☐ Male ☐ Female
4. **CLAIMANT IS A:** ☐ Referee ☐ Assessor ☐ Instructor ☐ Other
5. **ACCIDENT DATE:** _____/_____/_____ **ACCIDENT TIME:** _____ ☐ am ☐ pm
6. **BODY PART INJURED:**_____
7. **ACCIDENT OCCURRED DURING:** ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic
8. **IF ACCIDENT OCCURRED AT A TOURNAMENT, NAME OF TOURNAMENT**: _____
9. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**_____

_____

10. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:**_____

SECTION II - STATISTICAL INFORMATION - Required

TYPE OF GAME: ☐ COMPETITIVE ☐ RECREATIONAL

LOCATION: ☐ ON FIELD ☐ SIDELINES ☐ SPECTATOR AREA ☐ OTHER

SURFACE: ☐ DIRT ☐ GRASS ☐ OUTDOOR TURF ☐ INDOOR TURF

SURFACE CONDITION: ☐ DRY/NORMAL ☐ WET/RAINY ☐ ICY ☐ MUDDY

POSITION: _____

STATUS: ☐ HIT BY OBJECT ☐ OTHER_____

SECTION III - To Be Completed By New Jersey State Referee Committee - Only

POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	POLICY #	NAME OF POLICYHOLDER
August 1, 2012	**August 1, 2013**	**SRG 0009134695**	**NJ State Referee Committee**

ADDRESS OF POLICYHOLDER	TELEPHONE NUMBER
109 White Oak Ln, Suite 72H Old Bridge, NJ 08857	**732-607-1374**

Verify that the accident occurred during an activity sponsored or sanctioned by New Jersey State Referee Committee and whether claimant was a member at the time of the accident

☐ YES-Sponsored/Sanctioned Activity ☐ YES-Claimant Was Active Member On Date Of Accident

I certify that the foregoing information is true and correct.		
Authorized Signature	**Title**	**Date**

SECTION IV - STATEMENT OF OTHER INSURANCE (Required)

Claimant:

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ **ZIP**: _____

PHONE: _____

EMPLOYER: _____

EMPLOYER PHONE: _____

☐ Employed ☐ Self-Employed ☐ Unemployed

(If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.)

Is Claimant Covered Under A Government Sponsored Insurance Such As Medicare/Medicaid? ☐ YES ☐ NO

Is Claimant Covered Under Any Other Medical And Or Dental Insurance Policy? ☐ YES ☐ NO

INSURED NAME: _____ ID#: _____ INSURED GRP#/NAME: _____

COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

Please include a copy of both sides of your insurance card

SECTION V - ASSIGNMENT OF BENEFITS

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED UNLESS YOU PROVIDE PAID RECEIPTS FOR SERVICES RENDERED.

SECTION VI - STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (Required)

1. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or who makes a claim to receive benefits from this policy under false pretense; or conceals for the purpose of misleading, information concerning any fact material thereto; commits a fraudulent insurance act, which is a crime, and shall also be subject to a substantial civil penalty to the extent allowed by state law.

I have read this statement and agree that the information provided for this claim is true and correct.

SIGNATURE OF CLAIMANT (required): _____ **DATE:** _____

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Gracechurch Associates or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT (required): _____ **DATE:** _____

IMPORTANT

ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. **Accident medical expense coverage** under this policy is provided on an Excess Basis and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (e.g. to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment.

2. **Claim Guidelines**: You have 90 days from date of injury to submit claim form. However, do not wait for bill to arrive to file your claim. File your claim with NJ SRC as soon as possible after the injury occurs. For claims to be eligible for coverage you must seek medical attention within 60 days from date of injury.

   Benefit Period: This policy is subject to a **52 week** eligibility period from date of injury. Medical or dental expenses that are incurred **within 52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52 week** benefit period will not be covered by this policy.

3. **Please remember:**
   a) The NJ SRC must complete Section III of the claim form.
   b) Please make sure you have completed the entire claim form and signed where required.
   c) Advise your Providers/Hospitals of this insurance so they can file claims directly to Gracechurch Associates
   d) Attach all Explanation of Benefits (EOB) forms that you have received from your Primary Insurance carrier or other healthcare plan. However do not wait until you have received bills or EOBs to submit your claim form.
   e) Itemized bills are required. You must submit itemized bills; balance due bills will not be processed. See below for forms needed.
      1. HCFA-1500: standard form used by Providers
      2. UB-04 or UB-92: standard form used by Hospitals
   f) Payment of bills will follow the **usual and customary guidelines**. This means that the basis for payment of specific medical or dental claims is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.

4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before submitting the bills to Gracechurch Associates Insurance.

5. **Flex Spending, Health Reimbursement or Health Spending Accounts (HRA, HAS):** Please read below and follow the steps appropriately to submit information.

   1. **Employer contribution to flex account** – Primary insurance first, then flex account, then Gracechurch Associates

   2. **Employee contribution to flex account** – Primary insurance first, then Gracechurch Associates, the flex account. If monies have been paid out of your flex account before Gracechurch Associates, then those monies will need to be reimbursed to your flex account by your Providers. In order for claims to be processed by Gracechurch Associates, proof of reimbursement to your flex account is needed.

For further information contact:
Anthony J. Petruzzi
Gracechurch Associates
83 Big Oak Road
Morrisville, PA 19067
Phone: 1-215-295-0725
Email: apetruzzi@gracechurch.biz

Send this claim form for authorization to:
New Jersey State Referee Committee
109 White Oak Ln, Suite 72H
Old Bridge, NJ 08857
Phone:732-607-1374
Fax: 732-607-0296
Email: njrefoffice@verizon.net